Just 4 Kids
Pediatric Dentistry

Dr. Wendy Tang Inc.
Certified Specialist in Pediatric Dentistry

PATIENT INFORMATION

Name : ______________________
First Middle Initial Last

DOB (DD/MM/YY): ______________

Sex: M ☐ F ☐

Address: ______________________

City__________ Postal Code ________

Tel (Home): ______________________

MSP Card # ______________________

Referred by: ☐ Dentist ______________

☐ Friend ______________

☐ Sibling ☐ Drive-by/signage ☐ Internet

☐ Other (please specify)______________

Family dentist's name: ______________

Family doctor's name: ______________

Address: ______________________

Tel: ______________________

Names of siblings (if applicable)	Age	Patient of this office Yes	No
________	____	☐	☐
________	____	☐	☐
________	____	☐	☐

INSURANCE INFORMATION

☐ None

☐ Health Kids Program

Amount used $________ as of date ______

☐ Insurance through work (See below)

Primary Policy Holder #1: ______________

DOB (DD/MM/YY): ______________

Insurance Company: ______________

Group No. ________Div.____S.I.N.________

ID No. ______________________

Employer ______________________

Annual max. limit: $ /person; $ /family

Recall frequency: ☐ 6 mos ☐ 9 mos ☐ 12 mos

Primary Policy Holder #2: ______________

DOB (DD/MM/YY): ______________

Insurance Company: ______________

Group No. ________Div.____S.I.N.________

ID No. ______________________

Employer ______________________

Annual max. limit $ /person; $ /family

Recall frequency: ☐ 6 mos ☐ 9 mos ☐ 12 mos

PARENT/GUARDIAN INFORMATION

Mother/Guardian

Name: ______________________

DOB (DD/MM/YY): ______________

Occupation: ______________________

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Common Law ☐ Widowed ☐ Re-married

Address: ☐ Same as Patient

____

City__________ Postal Code ________

Tel (H): ______________________

(W): ______________ Ext. ________

(C): ______________________

E-mail: ______________________

Father/Guardian

Name: ______________________

DOB (DD/MM/YY): ______________

Occupation: ______________________

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Common Law ☐ Widowed ☐ Re-married

Address: ☐ Same as Patient

____

City__________ Postal Code ________

Tel (H): ______________________

(W): ______________ Ext. ________

(C): ______________________

E-mail: ______________________

HEALTH HISTORY

	YES	NO
1. Has your child ever had any serious illness? If yes, please explain________________________________	☐	☐
2. Has your child ever been hospitalized or had an operation? If yes, please explain__________________	☐	☐
3. Are your child's immunizations up-to-date?	☐	☐
4. Were there any complications surrounding the pregnancy or birth of your child?	☐	☐
5. Has your child ever had prolonged bleeding following a tooth extraction or minor injury?	☐	☐
6. Has you child ever had mild/moderate sedation or general anesthesia before? Any complications? If yes, please explain: ______________________________	☐	☐
7. Is there any history of familial sedation/anesthetic complications?	☐	☐
8. Is your child being treated for any medical condition at the present time or within the past year? If yes, please explain: ______________________________	☐	☐
9. Is your child taking any medication, non-prescription drugs or herbal supplements of any kind? If yes, please list: ______________________________	☐	☐
10. Is your child allergic to any medication (penicillin, pain killers, sulfa drugs, etc.) or have any adverse reactions to any medicines or injections? ______________________________	☐	☐
11. Does your child snore when sleeping or have any history of sleep apnea?	☐	☐

If your child currently **has** or **has ever had** any of the following, please check off the box (**otherwise, please leave blank**):

☐ Heart disease	☐ Hemophilia	☐ Skin disease (e.g. eczema)
☐ Heart attack	☐ Blood transfusion	☐ Visual, hearing or sinus problems
☐ Stroke	☐ Stomach ulcers	☐ Malignant hyperthemia
☐ Chest pain/angina	☐ Kidney disease	☐ Fainting spells
☐ Heart murmur	☐ Dialysis therapy	☐ Infectious disease
☐ Artificial heart valve	☐ Liver disease	☐ HIV/AIDS
☐ Mitral valve prolapse	☐ Jaundice	☐ Mental disability
☐ Pacemaker	☐ Hepatitis A, B, or C	☐ Learning disability
☐ High blood pressure	☐ Lung disease	☐ Attention Deficit disorder
☐ Shortness of breath	☐ Asthma	☐ Autism
☐ Rheumatic fever	☐ Bronchitis	☐ Speech delay
☐ Kawasaki's disease	☐ Tuberculosis (TB)	☐ Cerebral palsy
☐ Arthritis	☐ Diabetes (type 1 or 2)	☐ Seizure disorder/epilepsy
☐ Prosthetic/artificial joints	☐ Thyroid disease	☐ Cancer
☐ Sickle cell trait/disease	☐ Steroid therapy	☐ Allergies ____________________
☐ Bleeding/clotting disorder	☐ Immune deficiencies	☐ Others ____________________
☐ Anemia	☐ Drug/alcohol dependency	

DENTAL HISTORY

	YES	NO
1. What is the primary reason for this appointment? ______________________________		
2. When did your child last see a dentist? ______________ Reason for visit ________________________		
3. Is your child currently experiencing any dental pain? If yes, how long has it been? ______________	☐	☐
4. Is your child nervous during dental treatment? If yes, please explain:________________________	☐	☐
5. How do you expect your child to behave during today's visit? ☐excellent ☐fair ☐poor		
6. Has your child ever injured his/her teeth or mouth? If yes, please explain: ___________________	☐	☐
7. Does your child have any oral habits (e.g. digit sucking, pacifier, lip biting, teeth grinding)?	☐	☐
8. Who brushes your child's teeth? ☐Mom ☐Dad ☐Him/herself ☐Other ____________________ How often? _______ times/day		
9. Does your child use any toothpaste?	☐	☐
10. Does the toothpaste contain fluoride?	☐	☐
11. Does your child use floss? If yes, how often? ____________times/week	☐	☐
12. Does your child go to bed with a bottle? If yes, what's in the bottle? ________________________	☐	☐

I, the undersigned, verify that all of the medical and dental information provided is true to the best of my knowledge, and I have not knowingly omitted any information. I consent to my physician being contacted if necessary to obtain information that is required for my child's dental care. I authorize the dentist to perform the diagnostic procedures that may be required to determine the necessary treatment and assume financial responsibility for dental services rendered for my child.

Parent/Guardian signature ______________________________ Date ________________________

Reviewed by dentist ______________________________ Date ________________________